Exhibit 2

REQUEST FOR EMERGENCY MEDICAID CERTIFICATION

TO: Texas Department of Human Services Date: _____
Data Integrity, MC: 952-X
Austin, Texas 78714-9030 FAX: (512) 206-5801

1. Details of Life-threatening Medical Emergency: _____

2. Type of Recipient: (Circle One) Aged Blind Disabled

(Circle One) Individual Member of Couple

Individual with Ineligible Spouse

3. Type of Master Record (e.g., AX): _____

4. Date of SSI Application: _____
(Mo-Day-Year)

5. Month & Year of SSI Payment IN TEXAS: _____
(IC can be MOE; PE must be month after residency changed to Texas)

6. Full Name of Recipient: _____

7. Recipient's Social Security Number: _____

8. Title II or Medicare Claim Number: _____

9. DOB: _____ Sex: _____

10. Name and Address (as shown on check legend) Including Rep Payee: _____

11. Recipient's Telephone Number: _____

12. Special Instructions for TDHS Medicaid Card Delivery (e.g., who will pick it up): _____

13. Federal Living Arrangement (A, B, C, or D): _____

14. Unpaid Medical Expenses Prior 3 Months (Y or N): _____

15. Current Month Gross Unearned Income: $_____

16. Current Month Gross Earned Income: $_____

17. Gross RSDI Benefit Amount (breakout of 15): $_____